value usually above par, for the purpose of enabling the organization to reduce its indebtedness before maturity as occasion arises, or to take advantage of opportunities to borrow on more favorable terms. Bonds are often retired piecemeal through sinking fund operations.

ii. Costs incidental to the recall of bonds before their date of maturity are considered debt cancellation costs. Such costs include bond recall penalties, unamortized bond discounts and expenses, legal and accounting fees, etc. These costs must be reduced by any unamortized bond premiums and recorded in the Unrestricted Fund in accordance with Generally Accepted Accounting Principles.

6.10 Timing Differences

Timing differences result when accounting policies and practices used in an organization's accounting differ from those used for reporting operations to governmental units collecting taxes or to outside agencies establishing or making payments based upon the reported operations. These differences shall be reported on the hospital's records when they arise in accordance with relevant American Institute of Certified Public Accountants (AICPA) policies.

6.11 Self-insurance

(a) Self-insurance by a hospital for potential losses due to unemployment, and worker's compensation claims, but excluding self-insurance for employee health care, to be provided by the hospital asserted or otherwise, places all or part of the risk of such losses on the hospital rather than passing all or part of such losses to a third party. Where this method of insuring is used by the hospital, the payments into the fund or pool (if one is maintained) or payments on actual losses incurred shall be considered as insurance expense.

(b) It is required that where self-insurance for other than those items listed above is elected to be used by a facility, the method should conform with the following:

1. Self-Insurance Fund: The hospital or pool establishes a fund with a recognized independent fiduciary such as a bank or a trust company. The hospital or pool and fiduciary enter into a written agreement which includes all of the following elements:

i. General Legal Responsibility: The fiduciary agreement must include the appropriate legal responsibilities and obligations required by State laws.

ii. Control of Fund: The fiduciary must have legal title to the fund and be responsible for proper administration and control. The fiduciary cannot be related to the provider either through ownership or control. Thus, the home office of a chain organization or a religious order of which the hospital is an affiliate cannot be the fiduciary. In addition, investments which may be made by the fiduciary from the fund are limited to those approved under State law governing the use of such fund; notwithstanding this, loans by the fiduciary from the fund to the hospital or persons related to the hospital shall not be permitted.

iii. Payments by Fiduciary: The agreement must provide that withdrawals must be for malpractice and comprehensive general patient liability losses only and those expenses listed in (d) below. Any rebates, dividends, etc. to the hospital from the fund shall be used to reduce allowable cost. Furthermore, evidence of a practice of payments from the fund for purposes unrelated to the proper administration of the fund may result in a withdrawal of recognition of the self-insurance fund. In such instances, payments into the fund shall not be considered an allowable cost.

iv. Reporting: The agreement must require that a financial statement be forwarded to the hospital or pool members by the fiduciary no later than 60 days after the end of each

TN 93-11 Approval Date MAR 23 1993
Supersedes TN 89-11 Effective Date MAR 12 1993

annual insurance reporting period. This statement must show the balance in the fund at the beginning of the period, current period contributions, and amount and nature of final payments, including a separate accounting for claims management, legal expenses, claims paid, etc., and the fund balance. This report and fiduciary's records must be available for review and audit.

v. Income Earned: The agreement must provide that any income earned by the fund less any income taxes attributable to such income must become part of the Fund and must be used in establishing adequate fund levels.

2. Soundness of the Fund:

i. The hospital receives and retains an annual certified statement from an independent actuary, insurance company, or broker that has actuarial personnel experienced in the field of medical malpractice and general liability insurance. To be independent, there must not be any financial ownership or control, either directly or indirectly in the hospital.

ii. The actuary, insurance company, or broker shall determine the amount necessary to be paid into the fund. The fund should include reserves for losses based on accepted

actuarial techniques customarily employed by the casualty insurance industry and expenses related to the self-insurance fund as specified in (b) 4 below. The actuary, insurance company, or broker shall also provide for an estimate of the amounts to be in excess of what is reasonably needed to support anticipated disbursements from the fund.

iii. The actuary, insurance company, or broker must state the actuarial basis and the coverage period used in establishing reserve levels. Reserves shall not be recognized as allowable costs for losses specifically denied herein. Thus, reserve payments shall not be recognized for items such as:

(1) Losses in excess of the greater of 10 percent of a hospital's net worth or $100,000 where a hospital elects to pay losses directly in lieu of establishing a funded self-insurance fund;

(2) Losses in excess of coverage levels which do not reflect the decisions of prudent management; and

(3) Losses in excess of coverage for events that occurred prior to a hospital's participation under the Commission.

iv. The actuary, insurance company, or broker must provide its workpapers upon request.

3. Claims Management and Risk Management Program: A hospital or pool shall have an ongoing claims process and risk management program. The hospital or pool must demonstrate that it was an ongoing claims process to determine whether malpractice and comprehensive general patient liability exists, its cause, and the cost of claims. A hospital or pool may either utilize its qualified personnel or an independent contractor, such as an insurance company, to adjust claims. In addition, a hospital or pool must obtain adequate legal assistance in carrying out its claims process. Each hospital must also have an adequate risk management program to examine the cause of losses and to take action to reduce the frequency and severity of them. Such risk management program has the essential characteristics of programs required by insurers which currently insure providers for these risks. Therefore, a hospital must have an ongoing safety program and professional and employee training programs, etc., to minimize the frequency and severity of malpractice and comprehensive general patient liability incidents.

4. Expenses Related to Losses Paid Out of Self-Insurance Fund: The following expenses shall be considered costs attributable to a self-insurance fund established by a hospital or pool: expenses

of establishing the fund or pool; expenses for administering the claims management program; expenses involved with maintenance of the fund by the fiduciary; legal expenses; actuarial expenses; excess insurance coverage (if purchased by the fiduciary or pool); risk management (if performed by the fiduciary or pool), to the extent that such expenses are related to the hospital's self-insurance program. All other expenses shall not be considered costs attributable to the fund, but shall be included in provider administrative and general costs in the year incurred.

6.12 Related organizations

(a) Auxiliaries, guilds, fund raising groups and other related organizations frequently assist hospitals. Such organizations are independent if they are so characterized by their own charter, by-laws, tax-exempt status and governing board or a sufficient combination of these characteristics to demonstrate their independent existence from the hospital. The financial reporting of these organizations shall be separate from or combined with reports of the hospitals.

(b) A hospital itself may be a subsidiary to or under the control of a large organization such as a university, governmental entity or parent corporation. It is typical in such situations for hospitals to receive services from these related organizations. Examples of

services received are: administration; purchasing; general accounting; and menu planning. In addition, related organizations lease property, plant and equipment to hospitals, as well as paying for various other items, such as insurance. The related organization then usually charges for the service either directly or through a management fee. To be included as Costs Related to Patient Care, all such charges must be similar to those which would have been charged if the transacting organizations were not related. The direct charges must be recorded in the appropriate cost centers as billed, and the management fee must be distributed to the functional centers where services are provided. The hospital shall maintain documentation of the actual management service for which a management fee is recorded.

(c) Disclosure of information by hospitals dealing with related firm(s):

1. For the purpose of insuring prudent buying, hospitals shall report the existence of a related organization and each type of service provided, to the Department of Health, if the total transactions amount to greater than $10,000.00 per year.

2. Hospitals may be related to one or more separate organizations if:

i. The hospital controls through contracts or other legal documents the authority to direct the separate organizations management or policies;

ii. The separate organization controls through contracts or other legal documents the authority to direct the hospitals management or policies; and/or

iii. The hospital is for all practical purposes the primary beneficiary of the separate organization.

(d) At the Commission's request relevant information reported to the Commission may include:

1. The nature of the legal relationship betheen the hospital and the related firm(s).

2. Frequency of business transactions between the hospital and the firm(s);

3. Purchase or lease contractual arrangements between the hospital and firm(s);

4. The amount of money involved; and

5. The financial statements of all related organizations.

6.13 Financial Elements (Generally)

The financial elements of the rates shall include the reasonable cost of the following: direct patient care; depreciation and interest payments; paid taxes, excluding income taxes; and education, research and training programs, not otherwise paid for by the State. All non-direct costs must be allocated based upon the proportion of Medicaid clients serviced by the hospital.

6.14 Services Related to Medicaid Patient Care

(a) Services related to Medicaid Patient Care include Direct Patient Care; Paid Taxes excluding Income Taxes; and Educational, Research and Training Programs as further defined in Sections 6.14 through 6.21.

(b) Services Related to Patient Care include Routine Services, Ambulatory Services, Ancillary Services, Patient Care General Services, and Institutional Services. Costs Related to Patient Care include salaries and wages, physician compensation, employee fringe benefits, medical and surgical supplies, drugs, non-medical and non-surgical supplies, purchased services and other direct expenses and major moveable equipment costs as determined in accordance with Sections 6.22 through 6.26.